		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0002923

Facility Name: Heartland Manor Nursing Center

Address: 410 N. W. Third St. (Number) Casey (City) 62420 (Zip Code)

County: Clark

Telephone Number: (217) 932-4081 **Fax #** (217) 932-4922

IDPA ID Number: 370860567001

Date of Initial License for Current Owners: 12/18/64

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	X	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501(c)(3)			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Michael W. Martin **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/01 to 06/30/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/01 Ending: 06/30/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,135	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	837	67	2,024	2,928	8
9	SNF/PED					9
10	ICF	14,717	8,098		22,815	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,554	8,165	2,024	25,743	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.24%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Meals on Wheels

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 12/18/1964

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date N/A NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 28 and days of care provided 2,024

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/02 Fiscal Year: 06/30/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 **Report Period Beginning:** 07/01/01 **Ending:** 06/30/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7 **	8	9	10	
1	Dietary	227,720	13,546	7,075	248,341		248,341		248,341			1
2	Food Purchase		111,424		111,424		111,424	(11,735)	99,689			2
3	Housekeeping	85,459	15,930	591	101,980		101,980	(10,608)	91,372			3
4	Laundry	70,764	15,512	533	86,809		86,809		86,809			4
5	Heat and Other Utilities			84,475	84,475		84,475		84,475			5
6	Maintenance	46,932	3,623	46,707	97,262		97,262		97,262			6
7	Other (specify):*											7
8	**TOTAL General Services**	430,875	160,035	139,381	730,291		730,291	(22,343)	707,948			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,018,524	63,056	20,914	1,102,494		1,102,494		1,102,494			10
10a	Therapy		15,212	121,110	136,322		136,322		136,322			10a
11	Activities	66,163		4,691	70,854		70,854		70,854			11
12	Social Services	22,943		2,118	25,061		25,061		25,061			12
13	Nurse Aide Training			1,750	1,750		1,750		1,750			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,107,630	78,268	156,583	1,342,481		1,342,481		1,342,481			16
	C. General Administration											
17	Administrative	77,350			77,350		77,350		77,350			17
18	Directors Fees											18
19	Professional Services			94,094	94,094		94,094	(8,877)	85,217			19
20	Dues, Fees, Subscriptions & Promotions			11,415	11,415		11,415	(648)	10,767			20
21	Clerical & General Office Expenses	89,000	8,803	12,330	110,133		110,133	(58)	110,075			21
22	Employee Benefits & Payroll Taxes			305,118	305,118		305,118		305,118			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,507	6,507		6,507		6,507			24
25	Other Admin. Staff Transportation			974	974		974		974			25
26	Insurance-Prop.Liab.Malpractice			55,798	55,798		55,798		55,798			26
27	Other (specify):*											27
28	**TOTAL General Administration**	166,350	8,803	486,236	661,389		661,389	(9,583)	651,806			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,704,855	247,106	782,200	2,734,161		2,734,161	(31,926)	2,702,235			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

****See schedule of adjustments attached at end of cost report.**

Facility Name & ID Number Heartland Manor Nursing Center #0002923 Report Period Beginning: 07/01/01 Ending: 06/30/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7 **	8	9	10	
30	Depreciation			91,187	91,187		91,187	(2,637)	88,550			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			18,036	18,036		18,036	(734)	17,302			32
33	Real Estate Taxes			2,247	2,247		2,247	(2,247)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			111,470	111,470		111,470	(5,618)	105,852			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	12,950	50,266	4,039	67,255		67,255		67,255			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):* Nonallowable Costs			17,740	17,740		17,740	(17,740)				43
44	**TOTAL Special Cost Centers**	12,950	50,266	75,982	139,198		139,198	(17,740)	121,458			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,717,805	297,372	969,652	2,984,829		2,984,829	(55,284)	2,929,545			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/01 Ending: 06/30/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(11,735)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,093)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(356)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(2,637)	30		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(2,247)	33		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(8,877)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(8,115)	43		24
25	Fund Raising, Advertising and Promotional	(8,532)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached Supl pg. 1	(11,692)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (55,284)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (55,284)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Heartland Manor Nursing Center

ID# 0002923

Report Period Beginning: 07/01/01

Ending: 06/30/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 **Report Period Beginning:** 07/01/01 **Ending:** 06/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(11,735)	0	0	0	0	0	0	0	0	0	0	(11,735)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(11,735)	0	0	0	0	0	0	0	0	0	0	(11,735)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(8,877)	0	0	0	0	0	0	0	0	0	0	(8,877)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(8,877)	0	0	0	0	0	0	0	0	0	0	(8,877)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(20,612)	0	0	0	0	0	0	0	0	0	0	(20,612)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 **Report Period Beginning:** 07/01/01 **Ending:** 06/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(2,637)	0	0	0	0	0	0	0	0	0	0	(2,637)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(356)	0	0	0	0	0	0	0	0	0	0	(356)	32
33	Real Estate Taxes	(2,247)	0	0	0	0	0	0	0	0	0	0	(2,247)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(5,240)	0	0	0	0	0	0	0	0	0	0	(5,240)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(17,740)	0	0	0	0	0	0	0	0	0	0	(17,740)	43
44	**TOTAL Special Cost Centers**	(17,740)	0	0	0	0	0	0	0	0	0	0	(17,740)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(43,592)	0	0	0	0	0	0	0	0	0	0	(43,592)	45

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached schedule						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		N/A	$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4		N/A									4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9		N/A								9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/01 Ending: 06/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Union Planters Bank		X	New wing	$4,545.00	12/1996	$ 510,000	$ 146,289	1/2016	0.0775	$ 11,798	1
2												2
3	Leasehold obligations		X	Dishwasher	$59.00	6/1999	2,420	1,376	5/2004	0.1612	287	3
4	Leasehold obligations		X	Electric beds	$1,277.00	3/2001	38,225	22,089	3/2004	0.1204	3,297	4
5												5
	Working Capital											
6	Union Planters Bank		X	Line of credit	none	02/01/02	200,000		demand	0.0475	2,276	6
7												7
8	Various Vendors		X	Finance charges	none					various	378	8
9	TOTAL Facility Related				$5,881.00		$ 750,645	$ 169,754			$ 18,036	9
	B. Non-Facility Related*											
10												10
11												11
12								Less: interest income offset			(356)	12
13								Less: non-allowable finance charges			(378)	13
14	TOTAL Non-Facility Related						$	$			$ (734)	14
15	TOTALS (line 9+line14)						$ 750,645	$ 169,754			$ 17,302	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/01 Ending: 06/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1997	8
	1998	9
	1999	10
	2000	11
	2001	12

Facility is a not for profit entity and is exempt from real estate taxes.

Real estate tax is paid on non-care assets; however, this is adjusted out of the cost report per the instructions.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heartland Manor Nursing Center COUNTY Clark

FACILITY IDPH LICENSE NUMBER 0002923

CONTACT PERSON REGARDING THIS REPORT David J. Sauer

TELEPHONE 217-932-4081 FAX #: 217-932-4922

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200l

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	Facility pays real estate taxes		$	$
2.	on non-care assets. All costs		$	$
3.	are adjusted out of the cost report.		$	$
4.			$	$
5.	03-11-19-08-203-046	Lots 8 & 9 Sturdevant & Gobel Addn	$ 733.00	$ None
6.	03-11-19-08-203-047	Lots 4 & 5 Sturdevant & Gobel Addn	$ 286.64	$ None
7.	03-11-19-08-2036-049	Lot 2 Sturdevant & Gobel Addition	$ 1,227.72	$ None
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 2,247.36	$ None

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? See Above YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/01 Ending: 06/30/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,047 B. General Construction Type: Exterior Brick Frame Steel Number of Stories One

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground
(such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident care	152,472	1964	$ 24,000	1
2					2
3	TOTALS	152,472		$ 24,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	78		1964	1964	$ 385,838	$	25	$	$	$ 385,838	4
5			1966	1966	19,502		25			19,502	5
6			1970	1970	3,400		25			3,400	6
7			1972	1972	11,798		25			11,798	7
8	21		1996	1996	828,949	20,724	40	20,724		124,345	8
	Improvement Type**										
9	Building improvements			1973	7,123		10			7,123	9
10	Building improvements			1974	28,947	910	14-30	910		27,111	10
11	Building improvements			1975	7,064		10-30			7,064	11
12	Building improvements			1976	1,607	28	10-30	28		1,410	12
13	Building improvements			1977	1,808		7			1,808	13
14	Building improvements			1978	6,161		5-15			6,161	14
15	Building improvements			1979	3,730		10			3,730	15
16	Building improvements			1980	8,894		7			8,897	16
17	Building improvements			1981	1,376		7			1,376	17
18	Building improvements			1982	12,298		3-30			12,298	18
19	Building improvements			1983	6,263		5			6,263	19
20	Building improvements			1984	18,714		5-15			18,714	20
21	Building improvements			1985	8,044	858	5-15	858		8,044	21
22	Building improvements			1986	45,792	4,580	10-20	4,580		39,724	22
23	Building improvements			1987	28,030		5-15			28,030	23
24	Building improvements			1988	5,444	363	12-15	363		5,262	24
25	Building improvements			1989	3,775	251	15	251		3,206	25
26	Building improvements			1990	3,742		7			3,742	26
27	Building improvements			1991	6,380		10			6,380	27
28	Heating/air system			1992	80,277	4,014	20	4,014		44,822	28
29	Building improvements			1992	3,084	154	10	154		3,084	29
30	Building improvements			1992	2,168	126	10	126		2,168	30
31	Wallpaper			1992	308	20	10	20		308	31
32	Building improvements			1992	647	65	10	65		647	32
33	Building improvements			1992	4,263	284	15	284		2,771	33
34	Ceiling/floor			1992	49,925	2,498	20	2,498		23,403	34
35	Sprinkler system			1992	60,121	3,006	20	3,006		29,059	35
36	Storage shelving			1993	4,090	409	10	409		3,851	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Storage shelving	1993	$ 1,003	$ 100	10	$ 100	$	$ 953	37
38	Resident security system	1993	3,909	195	20	195		1,841	38
39	Cabinets	1993	42,611	2,311	15-20	2,311		19,560	39
40	Heating/air/tubs	1993	29,226	1,444	20	1,444		12,456	40
41	Fire alarm system	1993	12,350	618	20	618		6,741	41
42	Plumbing and water system	1993	8,684	434	20	434		4,016	42
43	Cubicle tracking	1993	1,768	177	10	177		1,635	43
44	Building improvements	1994	10,493	517	20	517		3,994	44
45	Building improvements	1995	24,889	2,053	10-20	2,053		12,596	45
46									46
47	Architect fees	1996	74,806	1,872	40	1,872		11,704	47
48	Hvac/insulation/ducts	1996	30,292	759	40	759		4,050	48
49	Sprinklers	1996	9,774	183	40	183		1,342	49
50	Painting	1996	4,052	76	40	76		418	50
51	General contractor fees	1996	7,841	147	40	147		1,078	51
52	Electrical	1996	18,390	460	40	460		2,875	52
53	Chapel work - New Hutton	1996	12,572	629	40	629		3,667	53
54	Cubicle curtain tracking	1996	742	37	20	37		229	54
55	Room signs	1996	3,331	167	20	167		999	55
56	Emergency lighting Jones wing	1996	142	7	20	7		46	56
57	Bath systems Jones wing	1996	8,610	431	20	431		2,583	57
58	Sprinklers Jones wing	1996	340	34	10	34		204	58
59	Security locks Jones wing	1996	1,049	52	20	52		315	59
60	Carpeting Jones wing	1996	3,436	172	20	172		1,031	60
61	Call lights Jones wing	1996	1,881	94	11	94		564	61
62	Air filtration Jones wing	1996	2,081	104	20	104		624	62
63	Wiring-computers & phone	1996	2,970		5			2,970	63
64	Hallway support bars	1996	750	75	10	75		444	64
65	Capitalized interest-new wing	1996	4,700	118	40	118		705	65
66	Plumbing	1996	4,640	232	20	232		1,501	66
67	Electrical work	1996	4,662	234	20	234		1,423	67
68	Flooring	1996	2,400	120	20	120		700	68
69	Courtyard	1996	2,766	138	20	138		818	69
70	TOTAL (lines 4 thru 69)		$ 1,996,722	$ 52,280		$ 52,280	$	$ 955,421	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,996,722	$ 52,280		$ 52,280	$	$ 955,421	1
2	Concrete work entrance	1996	1,470	74	20	74		429	2
3	Building appraisal	1997	2,578	64	40	64		360	3
4	Chapel HVAC	1997	2,324	116	20	116		642	4
5	Stained glass window	1997	2,052	103	20	103		539	5
6	Steel door	1997	422	21	20	21		109	6
7	Hot water heater - North Wing	1997	3,838	192	20	192		1,008	7
8	Hot water heater - Laundry	1997	2,893	145	20	145		735	8
9	Hand rails	1997	5,252	263	20	263		1,313	9
10	Painting	1997	478	24	20	24		118	10
11	Walk in cooler	1997	11,524	576	20	576		2,833	11
12	Fire system work	1997	513	26	20	26		124	12
13	Key pad - security system	1997	360	18	20	18		87	13
14	Hot water heater - Kitchen	1997	3,508	175	20	175		833	14
15	Tile flooring - Lobby	1997	900	45	20	45		214	15
16	Hot water heater	1998	7,318	366	20	366		1,647	16
17	Bed light installation	1998	1,826	91	20	91		396	17
18	Hand rails	1998	1,413	71	20	71		300	18
19	Sprinklers	1998	708	35	20	35		151	19
20	Generator bypass switch	1998	1,567	78	20	78		327	20
21	Carpeting in lobby (disposed of 2001-02 SEE NOTE on 12C)								21
22	Lighting - kitchen	1998	985	49	20	49		201	22
23	Paging system	1998	516	26	20	26		101	23
24	Room divider remodeling	1998	391	20	20	20		77	24
25	Bathroom lighting	1998	1,090	55	20	55		209	25
26	South wing remodeling	1998	165	8	20	8		31	26
27	Roof over generator room	1998	568	28	20	28		109	27
28	Bathrooms	1998	7,394	370	20	370		1,386	28
29	Bathrooms-South & Hutton	1998	6,197	310	20	310		1,111	29
30	Fire Alarm System	1999	1,317	66	20	66		214	30
31	Fire & Smoke Dampers	1999	1,664	83	20	83		257	31
32	Generator Work for Heating	1999	1,760	88	20	88		279	32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,069,713	$ 55,866		$ 55,866	$	$ 971,561	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,069,713	$ 55,866		$ 55,866	$	$ 971,561	1
2									2
3									3
4	Generator panel	2000	2,023	202	10	202		523	4
5	Gazebo	2000	2,733	273	10	273		410	5
6	Anti-scald valves (2)	2001	655	65	10	65		98	6
7	Shower floor replacement	2001	500	25	20	25		38	7
8	Dining room lights	2001	6,013	301	20	301		451	8
9									9
10	Toilet stools & seats	2001	1,414	125	10	125		125	10
11	Parking lot asphalt reseal	2001	5,032	189	20	189		189	11
12	Ceramic wall tile	2001	365	14	20	14		14	12
13	Washer & nurse call	2001	485	28	10	28		28	13
14	Bath fans	2001	150	9	10	9		9	14
15	Extend legs on links	2001	607	35	10	35		35	15
16	Wallpaper front lobby	2001	150	11	10	11		11	16
17	Remodel North & South showers	2002	2,332	29	20	29		29	17
18	Dorma 7605 EMF-T pullside fire door closers	2002	912	23	10	23		23	18
19	Water heater	2002	4,165	17	20	17		17	19
20									20
21									21
22	Reconciling items								22
23	Variance in IDPA records & cost report - 1992		26,230						23
24	Variance in IDPA records & cost report - 1993		(22,330)						24
25									25
26									26
27									27
28									28
29	NOTE:								29
30	Disposition: Lobby carpeting (98) recorded @ 727								30
31	with accum. depr of 152								31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,101,149	$ 57,212		$ 57,212	$	$ 973,561	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 444,176	$ 28,691	$ 28,691	$	5-15	$ 283,976	71
72	Current Year Purchases	34,270	2,647	2,647		10	2,647	72
73	Fully Depreciated Assets	92,646					92,646	73
74								74
75	TOTALS	$ 571,092	$ 31,338	$ 31,338	$		$ 379,269	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident care	1994 Ford van	1994	$ 41,610	$	$	$	5	$ 41,610	76
77										77
78										78
79										79
80	TOTALS			$ 41,610	$	$	$		$ 41,610	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,737,851	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 88,550	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 88,550	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,394,440	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Alinski bldg - 1994	$ 40,045	$ 1,027	$ 7,958	86
87	Alinski parking lot - 1996	3,900	195	1,105	87
88	Delaware house - 1998	17,550	450	1,913	88
89	Land - 1994, 1998, 2000	30,000			89
90	Repp House - 2000	38,500	965	1,564	90
91	TOTALS	$ 129,995	$ 2,637	$ 12,540	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/01 Ending: 06/30/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ N/A Description: N/A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/01 Ending: 06/30/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	
IN OTHER FACILITY	
COMMUNITY COLLEGE	X
HOURS PER AIDE	80

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER AIDE	40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments		1,750		1,750
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 1,750	$	$ 1,750
10	SUM OF line 9, col. 1 and 2 (e)	$ 1,750			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	7
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	7

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A (2), (3)	hrs	$	3,447	$ 51,706	$ 1,902	3,447	$ 53,608	1
2	Licensed Speech and Language Development Therapist	10A (3)	hrs		578	8,664		578	8,664	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A (3)	hrs		4,049	60,740		4,049	60,740	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				46,709		46,709	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39 (1),(2)	1110	12,950			3,557	1,110	16,507	12
13	Other (specify): See Supl pg 1	10A(2) & 39(3)				4,039	13,310		17,349	13
14	TOTAL			$ 12,950	8,074	$ 125,149	$ 65,478	9,184	$ 203,577	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/01 Ending: 06/30/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 48,028	$ 48,028	1
2	Cash-Patient Deposits	6,526	6,526	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 6,000)	473,132	473,132	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	23,452	23,452	6
7	Other Prepaid Expenses	33,705	33,705	7
8	Accounts Receivable (owners or related parties)	9,900	9,900	8
9	Other(specify): Investments	351	351	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 595,094	$ 595,094	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	54,000	24,000	13
14	Buildings, at Historical Cost	2,169,907	2,101,149	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	596,362	612,702	16
17	Accumulated Depreciation (book methods)	(1,361,699)	(1,394,440)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,458,570	$ 1,343,411	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,053,664	$ 1,938,505	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 102,039	$ 102,069	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,526	6,526	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	119,581	119,581	30
31	Accrued Taxes Payable (excluding real estate taxes)	28,939	28,939	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	495	495	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Employee Annuity & Credit Union	2,172	2,172	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 259,752	$ 259,782	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	146,289	146,289	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Leasehold Obligations	23,465	23,465	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 169,754	$ 169,754	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 429,506	$ 429,536	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,624,158	$ 1,508,969	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,053,664	$ 1,938,505	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/01 Ending: 06/30/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,649,947	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,649,947	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(25,789)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (25,789)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,624,158	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/01 Ending: 06/30/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,714,527	1
2	Discounts and Allowances for all Levels	(119,112)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,595,415	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	173,736	6
7	Oxygen	19,788	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 193,524	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	11,735	14
15	Telephone, Television and Radio	1,718	15
16	Rental of Facility Space	7,100	16
17	Sale of Drugs	47,078	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,880	19
20	Radiology and X-Ray		20
21	Other Medical Services	67,669	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 138,180	23
	D. Non-Operating Revenue		
24	Contributions	10,716	24
25	Interest and Other Investment Income***	356	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 11,072	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See attached	20,849	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 20,849	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,959,040	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	730,291	31
32	Health Care	1,342,481	32
33	General Administration	661,389	33
	B. Capital Expense		
34	Ownership	111,470	34
	C. Ancillary Expense		
35	Special Cost Centers	84,995	35
36	Provider Participation Fee	54,203	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,984,829	40
41	**Income before Income Taxes (line 30 minus line 40)****	(25,789)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (25,789)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/01 Ending: 06/30/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,864	2,080	$ 41,814	$ 20.10	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,360	15,405	259,474	16.84	3
4	Licensed Practical Nurses	13,308	14,281	195,681	13.70	4
5	Nurse Aides & Orderlies	56,621	59,277	506,819	8.55	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,088	2,224	19,698	8.86	9
10	Activity Assistants	6,328	6,556	46,465	7.09	10
11	Social Service Workers	2,044	2,198	22,943	10.44	11
12	Dietician					12
13	Food Service Supervisor	1,864	2,080	24,186	11.63	13
14	Head Cook	6,998	7,119	60,809	8.54	14
15	Cook Helpers/Assistants	12,099	12,698	116,048	9.14	15
16	Dishwashers	4,755	4,755	26,677	5.61	16
17	Maintenance Workers	4,305	4,441	46,932	10.57	17
18	Housekeepers	11,452	11,956	85,459	7.15	18
19	Laundry	9,833	10,266	70,764	6.89	19
20	Administrator	1,864	2,080	77,350	37.19	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,864	2,080	29,870	14.36	23
24	Clerical	4,927	5,344	59,130	11.06	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Ca Careplan Coord.	2,131	2,394	27,686	11.56	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	158,705	167,234	$ 1,717,805 *	$ 10.27	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	115	$ 5,542	1(3)	35
36	Medical Director	29	6,000	9(3)	36
37	Medical Records Consultant	20	1,560	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	935	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	2,118	11(3)	44
45	Social Service Consultant	48	2,118	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	272	$ 18,273		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	39	1,350	10(3)	51
52	Nurse Aides	102	1,882	10(3)	52
53	TOTAL (lines 50 - 52)	141	$ 3,232		53

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/01 Ending: 06/30/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
David J. Sauer	Administrator	0	$ 77,350
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 77,350

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Duane Morris	Legal	$ 50,837
Meehling & Bernardoni	Legal	250
Dennis Simonson	Legal	820
James Grant	Legal	802
American Expr. Tax & Bus. Svc.	Accounting	3,930
Larsson Woodyard Henson	Accounting	9,600
Altschuler Melvoin & Glasser	Accounting	8,786
Williams & Randall	Operation consultant	12,723
National Trail Banking Ctr.	Alarm monitor service	215
Quorum consulting	Operations consult	2,948
Personnel Planners	Unemployment consultant	810
Charlie & Company	Computer programming	2,373
TOTAL (agree to Schedule V, line 19, column 3) (See Attached)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 94,094

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 31,080
Unemployment Compensation Insurance	5,405
FICA Taxes	130,407
Employee Health Insurance	97,328
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Morale	3,212
Employee Labs & Physicals	473
Employee Life & Additional Health Insurance	37,213
TOTAL (agree to Schedule V, line 22, col.8)	$ 305,118

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
	N/A	
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 24)	288
Various Licenses	135
Illinois Health Care Assn Dues	5,633
AHCA Facilitator Fees	1,315
NAEIR Dues	475
Miscellaneous Dues	2,329
Miscellaneous Subscriptions	1,240
Less: Public Relations Expense	(648)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,767

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
See attached schedule	6,507
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,507

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/01 Ending: 06/30/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6			N/A										
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/01 Ending: 06/30/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Assn - 5,633**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **2,543** Line **10(2)**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **54,203**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **Yes** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **11,735**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Larsson, Woodyard & Henson** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **No** If no, please explain. **Will provide copy when complete.**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Heartland Manor Nursing Center
Facility #: 00002923
07/01/01 - 06/30/02 **Supplementary Information**

Page 2 - Schedule III E:

Non-allowable costs have been eliminated in Schedule V, Column 7

Page 5 - Schedule VI - Adjustments

Non-allowable costs	Amount	Ref.
Finance charges	(378)	32
Chamber of Commerce & service club dues	(648)	20
Late fees	(58)	21
Cleaning expense related to non-care asset	(10,608)	3
	(11,692)	

Page 6 - Schedule VII A - Non-Profit required attachment - Board of Directors:

Board Member	Directly Provided Services	Type of Services	Entity owned doing business with facility	Type of business conducted
David Hensiek (Pres)	yes	Auto parts	Hutton Auto Parts	Maint. Supplies
Betty Styer	no			
Marilyn Resch (Secy)	no			
Ted Perillo (V Pres)	yes	Pharmacy	Pharmacy Shop	Pharmacy
Tom Marsh	no			
Jim Niksch	no			
Mark Ahrens	yes	Grocery	Casey IGA	Food

Page 16 - Schedule XIV. Special Services - Line 13 - Other

	Line Reference	Outside Practitioner Units	Outside Practitioner Cost	Outside Practitioner Supplies
Respiratory Therapy	L10A, C2			13,310
Medicare Oxygen	L39, C3	N/A	2,291	
Medicare Lab	L39, C3	N/A	1,474	
Medicare Radiology	L39, C3	N/A	274	
Total			4,039	13,310

Page 19 - Schedule XVII, Line 28 - Other Revenue:

Vending machine commissions	820
Oil income	249
Cleaning income	18,000
Sale of miscellaneous obsolete equipment	719
Sale of supplies	750
Various	311
	20,849

Page 21 - Schedule XIX (C) - Professional Services

Total (agree to Schedule V, line 19, column 3)	94,094
Out of period legal costs	(8,057)
Nonallowable collection fees	(820)
Total (agree to Schedule V, line 19, column 8)	85,217

Page 23 - Schedule XX, Question 12 - Employee allocated to two lines on Schedule V

One employee scheduled 20 hours per week in Laundry and 20 hours per week working in Housekeeping. Wages allocated on actual hours worked in the appropriate department.

RECONCILIATION REPORT **Heartland Manor Nursin** **03:04 PM** **11/04/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-55,284	equal to	-55,284	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	17,302	equal to	17,302	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	88,550	equal to	88,550	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	0	equal to	0	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	1,750	equal to	1,750	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages	12,950	equal to	12,950	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	123,012	equal to	136,322	-13,310	FAILED	Pg16 Z12+Z14...	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	65,478	equal to	65,478	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	730,291	equal to	730,291	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,342,481	equal to	1,342,481	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	661,389	equal to	661,389	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	111,470	equal to	111,470	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	84,995	equal to	84,995	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	54,203	equal to	54,203	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	1,003,788	equal to	1,018,524	-14,736	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	12,950	-12,950	FAILED	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	66,163	equal to	66,163	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	22,943	equal to	22,943	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	227,720	equal to	227,720	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	46,932	equal to	46,932	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	85,459	equal to	85,459	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	70,764	equal to	70,764	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	77,350	equal to	77,350	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	89,000	equal to	89,000	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,717,805	equal to	1,717,805	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	5,542	< or = to	7,075	-1,533	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	6,000	< or = to	6,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	5,727	< or = to	20,914	-15,187	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	2,118	< or = to	4,691	-2,573	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	2,118	< or = to	2,118	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	77,350	equal to	77,350	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other		equal to		0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	94,094	equal to	94,094	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	305,118	equal to	305,118	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	10,767	equal to	10,767	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	6,507	equal to	6,507	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	54,203	equal to	54,203	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to		0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	2,024	equal to	2,024	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs		equal to	0	#VALUE!	#VALUE!	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	169,754	equal to	146,289	23,465	FAILED	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	0	equal to		0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	24,000	equal to	24,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	2,101,149	equal to	2,101,149	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	612,702	equal to	612,702	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,394,440	equal to	1,394,440	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	1,624,158	equal to	1,624,158	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-25,789	equal to	-25,789	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	2,053,664	equal to	2,053,664	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

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Line 16 for mortgage insurance.